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Supreme Court, U.S.
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No. 09-474

IN THE

Supreme Court of the United States

JAY DOROSHOW,

Petitioner,

v.

HARTFORD LIFE AND ACCIDENT INSURANCE CO.,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

BRIEF IN OPPOSITION

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QUESTION PRESENTED

Whether the court of appeals correctly applied the "deferential standard" of *Metropolitan Life Insurance Co.* v. *Glenn*, 128 S. Ct. 2343 (2008) to conclude that there was substantial evidence in support of a claim administrator's determination that a doctor's tentative assessment about a condition—"Was not thought to be [Amyotrophic Lateral Sclerosis]"—constituted advice for that condition, in light of the insured's family history, medical record, commonality between ALS and insured's diagnosed condition of motor neuron disease, and progressive nature of ALS, thus triggering a pre-existing condition exclusion under a disability insurance policy.

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BRIEF IN OPPOSITION

STATEMENT

Petitioner Jay Doroshow was a participant in an employee welfare plan that provided long-term disability benefits. The plan was governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. §§ 1001 *et seq.*, and funded by an insurance policy administered by Hartford Life and Accident Insurance Company. The policy excluded coverage for any loss resulting from a pre-existing condition, which in turn was defined as "a condition for which medical treatment or advice was rendered, prescribed, or recommended" within a three-month look-back period before the policy's effective date of coverage. Pet. 3 (internal quotation marks omitted).

During the look-back period, petitioner was diagnosed by his primary physician, Dr. Arnold Goldstein, as having motor neuron disease (MND), which was described at the time as lumbosacral plexitis and "[w]as not felt to be ALS [Amyotrophic Lateral Sclerosis]." *Doroshow* v. *Hartford Life & Accident Ins. Co.*, No. 2:08-cv-00259-RK, Dkt. No. 9, at HLI0057 (E.D. Pa. Apr. 7, 2008). Even before the look-back period, petitioner had received advice and testing related to ALS. For instance, one doctor found petitioner to have "[c]hronic active denervation of right leg, arm, paraspinal and bulbar muscles," which were "features of a motor neuron disease." *Id.* at HLI0072. This doctor observed that "[i]f the left Babinski sign is a consistent feature, then [petitioner] has the ALS form of motor neuron disease," and recommended that petitioner see an ALS specialist. *Id.* The ALS specialist found evidence of a lower motor neuron problem, but no signs of an upper motor neuron problem, and concluded that the former symptoms at the time did not support an ALS diagnosis. *Id.* at HLI0116. Both doctors noted petitioner's family history of ALS. *Id.* at HLI0071, 116.

After the effective date of the policy, petitioner was conclusively diagnosed with ALS and applied for long-term disability benefits. Hartford denied petitioner's claim based on the pre-existing condition exclusion. In its letter to petitioner, Hartford stated:

> Our review of all the medical information in your claim file shows that you are claiming benefits because of symptoms related to motor neuron disease (MND), which includes amyotrophic lateral sclerosis (ALS). The medical records obtained from the office of Dr. Goldstein indicate that you were treated for this condition [during the look-back period]. ALS was

> discussed in this [office visit], likely due to the type of symptoms you were experiencing and the family history of this disease. Intermittent workup and follow up continued for your reported symptoms until definitive diagnosis [during the policy's period of coverage.]

Pet. App. 21a.

Reviewing the benefits decision for abuse of discretion, the district court found that there was substantial evidence showing that petitioner received advice for ALS during the look-back period. The court noted that "[a]dvice is a broader concept than treatment, and a doctor's conclusion that a patient is not suffering from a certain condition constitutes an opinion or recommendation offered as a guide to action," a dictionary meaning of "advice" adopted by the court and uncontested by the parties. Pet. App. 32a. Moreover, the court found that ALS "was considered by all ... doctors who examined" petitioner before the effective date of coverage. Pet. App. 33a. Based on a medical treatise, the court observed that ALS "'is the most common form of progressive motor neuron disease'" and when lumbosacral motor neurons are affected, "diagnosis [of ALS] is 'possible.'" Pet. App. 33a n.2 (quoting Anthony S. Fauci, M.D., et al., *Harrison's Principles of Internal Medicine* 2572, 2573 (17th ed. 2008)). Finally, the Court noted that when "a patient exhibits signs of a motor neuron problem, ALS is routinely considered as a possible condition by members of the medical community." *Id.*

The court of appeals affirmed the district court's judgment, finding "Dr. Goldstein's notes related to ALS particularly compelling in the broader context of Doroshow's entire medical history." Pet. App. 10a.

Furthermore, the court observed that due to the "progressive nature of the disease, it is not surprising that, when Doroshow first began exhibiting symptoms, the doctors did not conclusively determine that he had ALS, but more generally said only that he had a form of motor neuron disease." Pet. App. 11a. Thus, based on petitioner's "family history of ALS and his medical records," the court concluded "that it is clear that Doroshow sought advice for ALS when he visited Dr. Goldstein during the look-back period." Pet. App. 13a. Petitioner's request for en banc review was denied by the Third Circuit, with eight out of eleven active judges not voting for rehearing (Pet. App. 38a-39a), rather than six as alleged by petitioner (Pet. 1).

REASONS FOR DENYING THE WRIT

I. THERE IS NO IMPORTANT QUESTION OF FEDERAL LAW RAISED BY PETITIONER

Petitioner's argument reduces to a request that this Court correct the Third Circuit's application of this Court's decision in *Metropolitan Life Ins. Co.* v. *Glenn*, 128 S. Ct. 2343 (2008) to the particularized facts of this case, a submission that does not warrant this Court's review. Indeed, petitioner acknowledges that just last Term, *Glenn* restated the legal standard to be applied by lower courts reviewing claim administrators' benefit decisions under ERISA. Pet. 5. Petitioner neither challenges the legal standard of review nor argues that the Third Circuit acted in contravention of any other Supreme Court precedent. Because he challenges only the application of the *Glenn* standard to the particularized facts of his case, there is no need for further guidance from the Court on the question raised by petitioner.

In *Glenn*, the Court confirmed the previous standard of review established in *Firestone Tire & Rubber*

Co. v. *Bruch*, 489 U.S. 101 (1989), under which courts apply a deferential standard for abuse of discretion in cases where, as here, an insurance plan grants an administrator discretionary authority to determine eligibility for benefits. The Court also clarified that a claim administrator, that both determines eligibility and pays benefits, has a structural conflict of interest that does not change the abuse of discretion standard. Instead, the Court held that such structural conflict should be weighed as one factor in determining whether there was an abuse of discretion. *See* 128 S. Ct. at 2346. Finally, the Court emphasized the complex and fact-intensive nature entailed in judicial review of benefits decisions:

> Benefits decisions arise in too many contexts, concern too many circumstances, and can relate in too many different ways to conflicts—which themselves vary in kind and in degree of seriousness—for us to come up with a one-size-fits-all procedural system that is likely to promote fair and accurate review.

Id. at 2351.

Petitioner seeks to turn a complex factual question, contingent on the particularized context of each case, into a bright-line legal question. Pet. 5 ("[P]etitioner contends that it is *never* reasonable to construe a negative diagnosis as advice." (emphasis added)). Petitioner's arguments aim to relitigate the application of the abuse of discretion standard articulated in *Glenn* that was fully considered thrice below by the district court, a court of appeals panel, and the full en banc court of the Third Circuit, in light of petitioner's family history, medical record, the commonality between ALS and MND, and the progressive nature of ALS.

Moreover, the Question Presented embeds a new argument not made in the record of the administrative proceeding or argued in the district court—that the physician's note cannot be "advice" because it was not offered to petitioner. Pet. 6, 11-12. Indeed, although petitioner challenged in writing the denial of benefits as a result of the physician's note, he did so not for the reason that the advice recorded in the note was never provided to him, but rather on the asserted basis that the physician believed that ALS "was not likely" and thus petitioner's later diagnosis could not be applied "retroactively." *Doroshow* v. *Hartford Life & Accident Ins. Co.*, No. 2:08-cv-00259-RK, Dkt. No. 9, at HLI0048-49 (E.D. Pa. Apr. 7, 2008). Since petitioner raised this issue for the first time on appeal, the court of appeals did not address it, evidently—and correctly—deeming the argument waived in light of his failure to preserve it in the district court. *See Webb* v. *City of Phila.*, 562 F.3d 256, 263 (3d Cir. 2009) (Scirica, C.J.) ("Generally, failure to raise an issue in the District Court results in its waiver on appeal." (internal quotation marks omitted) (citing cases)). Having waived that argument below, petitioner raises this issue in this Court in an improper posture.

Finally, petitioner profoundly mischaracterizes the district court's opinion in *Cohen* v. *Metropolitan Life Insurance Co.*, 485 F. Supp. 2d 339 (S.D.N.Y. 2007), which involved significantly different facts from the circumstances here and does not stand for the holdings contended by petitioner. Pet. 6-10. In *Cohen*, the court found the claim administrator's decision that "receiving *any* medical care or treatment during a look-back period disqualified a participant from receiving disability benefits" as "fundamentally unreasonable" since the insurance plan clearly stated that such medical care or

treatment must relate to the sickness that gave rise to the claimed disability. 485 F. Supp. 2d at 349-350 (emphasis in original). In addition, the court noted that the administrator "merely identifie[d] a degree of facial similarity between certain of the symptoms [such as tiredness] prior to and during the look-back period and those ... cited many months later as preventing [insured] from working," namely, Chronic Fatigue Syndrome (CFS). *Id.* at 350. The failure to associate a generic symptom, such as tiredness, with CFS is not analogous to the express acknowledgment of the possibility of ALS along the progressive spectrum of MND, with which petitioner was specifically diagnosed during the look-back period. In *Cohen*, there also was no family history of the disease as was the case with petitioner.

In addition, the *Cohen* court found significant procedural irregularities underlying the denial decision, such as the claim administrator's "failure to provide notice to [the insured] of its consideration of materials [obtained from insured's doctors] in addition to those disclosed following its initial denial" and its subsequent refusal to consider insured's submissions in response to these additional materials. 485 F. Supp. 2d at 353. Such "failure to comply with ERISA's full and fair review mandate," the court concluded, "rendered [the] decision arbitrary and capricious." *Id.* Here, in contrast, the district court found that "Doroshow ha[d] not produced any evidence of procedural anomalies." Pet. App. 30a.

Rather than holding, as claimed by petitioner, "that the insurer's preexisting condition did not apply as a matter of law" (Pet. 7), the *Cohen* court based its decision on the "entire administrative record" involving the weighing of a complex set of particularized facts listed

above, 485 F. Supp. 2d at 354. Thus, petitioner has failed to demonstrate that lower courts would have reached different conclusions even if presented with the same facts.

The only potential relevance of *Cohen* is to demonstrate, as petitioner concedes, that the particularized set of facts raised by this case is of "first impression" (Pet. 2, 6), and thus has not yet been fully developed in the lower courts. *See* Eugene Gressman et al, *Supreme Court Practice* 504 (9th ed. 2007). This Court's scarce resources ought not be burdened to provide guidance on the application of *Glenn* to these specific facts, particularly where *no* other court has yet addressed this issue in the context of progressive, hereditary diseases such as ALS. The issue raised by petitioner would thus benefit from further percolation as more courts review application of pre-existing condition clauses in ERISA plans in the context of advice regarding a family of related, progressive diseases. Thus, there is no important question of federal law for the Court to consider.

II. THERE IS NO CONFLICT BETWEEN THE THIRD CIRCUIT DECISION AND ANY DECISION OF THIS COURT, OTHER CIRCUIT COURTS, OR PRIOR THIRD CIRCUIT CASES

Petitioner has failed to identify a single decision of this Court or other circuit courts, with which the Third Circuit decision is purported to be in conflict. Indeed, there is none. That fact alone justifies denial of the petition, as there is no allegation that the Third Circuit's decision will produce any conflict with other decisions that would result in confusion or differing implementation of ERISA in varying jurisdictions across the country.

Although petitioner attempts to portray a conflict between the court of appeals' opinion here and two prior decisions in the Third Circuit (Pet. 13-19), there is

no such conflict. Even if there were such conflict, it would not be appropriate for this Court's review. As this Court has long held, alleged conflicts within a circuit court are supposed to be resolved internally in the circuit by rehearing en banc. *See* Gressman et al., *Supreme Court Practice* 503. Here, the Third Circuit provided such review and categorically rejected petitioner's claims, with all but three of eleven judges of the full active court not voting for rehearing en banc.

As the court of appeals panel held, there is no conflict between its decision and prior Third Circuit decisions. The panel pointed out that the two cases cited by petitioner—*McLeod* v. *Hartford Life & Accident Insurance Co.*, 372 F.3d 618 (3d Cir. 2004) (Becker, J.) and *Lawson* v. *Fortis Insurance Co.*, 301 F.3d 159 (3d Cir. 2002) (Alito, J.)—concerned a "misdiagnosis or an unsuspected condition manifesting non-specific symptoms," which thus did not trigger the pre-existing condition exclusion. Pet. App. 13a (internal quotation marks omitted). In *McCleod* and *Lawson*, the plaintiffs were treated for numbness and respiratory tract infection, respectively, but were not suspected to have, or diagnosed with, the multiple sclerosis and leukemia that subsequently caused their respective disabilities. In contrast, the Third Circuit held in this case that petitioner "had a suspected condition without a confirmatory diagnosis, which may appropriately be deemed a pre-existing condition." Pet. App. 13a (internal quotation marks omitted). Distinguishing a misdiagnosis or unsuspected condition from a suspected condition without a confirmatory diagnosis, the *Lawson* court noted:

> [In cases where] the claimants suspected a particular condition when they saw their physicians, it might make sense to say that the claimants had received advice or treatment

> "for" their respective conditions, although they had not been definitively diagnosed. In both instances, a particular condition was suspected; treatment, advice, or testing for that suspected condition was provided; and the pre-effective date treatment, advice, or testing turned out to be "for" the condition that was ultimately diagnosed.

301 F.3d at 165-66. *See also McLeod*, 372 F.3d at 629 (neither the insured nor the insured's doctors "either knew or suspected that the symptoms [insured] was experiencing were in any way connected" with the subsequent condition giving rise to the benefits claim).

The unpublished opinion in *Ceccanecchio* v. *Continental Casualty Co.*, 50 F. App'x 66 (3d Cir. 2002) provides no basis for this Court's review. Because the Third Circuit does not recognize unpublished decisions as precedential, Internal Operating Procedure Rule 5.7, the panel here did not address *Ceccanecchio*. *See Jamison* v. *Klem*, 544 F.3d 266, 278 n.11 (3d Cir. 2008) (McKee, J.) ("We have steadfastly attempted to discourage District Courts as well as attorneys from relying on nonprecedential opinions of this court."). In any event, the facts in *Ceccanecchio* are similar to *McLeod* and *Lawson*, and distinct from the case here, insofar as the insured underwent a routine gynecological exam, at which the doctor noted urinary frequency and urgency, and nocturia four times the previous year, but did not suspect or diagnose the severe case of interstitial cystitis that subsequently caused the insured's disability.

Finally, three different standards of review were applied in the three precedential Third Circuit decisions alleged to be in conflict by petitioner. *Lawson*, arising out of a breach of contract claim rather than a

claim under ERISA, was decided based on a *de novo* standard of review. *McLeod* used a heightened arbitrary and capricious standard of review. Here, the court of appeals applied the abuse of discretion standard of review confirmed by the Supreme Court in *Glenn*. Clearly, courts reviewing benefits determinations based on different standards of review applied to complex and particularized facts may reach different results. Indeed, the *McLeod* court observed that if a non-heightened standard of review applied to the facts before it, and the insurer had "provided a plausible reason for its interpretation, then perhaps the result [of the case] would be different." 372 F.3d at 624.

Thus, there is no conflict between the Third Circuit decision and any decision of this Court, other circuit courts, or prior Third Circuit cases.

CONCLUSION

For the foregoing reasons, the Petition for a Writ of Certiorari should be denied.

Respectfully submitted.

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